Abide Health Medical APC

6847 W. Charleston Blvd. Suite B
Las Vegas, NV 89117
Phone #: (725) 205-1578 Fax #: (725) 485-3749

Patient Rights and Responsibilities

At **Abide Health Medical APC**, we are committed to providing high-quality care that respects your dignity and rights. This document outlines your rights and responsibilities as a patient in our care. Please read this form carefully, and feel free to ask questions about any information you do not understand.

Patient Rights

As a patient receiving healthcare services from **Abide Health Medical**, you have the following rights:

1. **Right to Receive Quality Care**
   You have the right to receive care that is **safe, appropriate, and effective**, consistent with your individual needs and condition.
2. **Right to Informed Consent**
   You have the right to be informed about your diagnosis, treatment options, and any potential risks or benefits. You have the right to give or withhold consent for treatment and may choose to **withdraw consent at any time** without fear of retaliation.
3. **Right to Confidentiality**
   You have the right to have your **health information** kept confidential in accordance with **HIPAA** (Health Insurance Portability and Accountability Act) and **Nevada state law**. Your healthcare provider will only disclose your health information with your consent or when required by law.
4. **Right to Choose Your Healthcare Provider**
   You have the right to choose your **healthcare provider** and request a second opinion, unless it is an emergency situation where immediate care is needed.
5. **Right to Respect and Dignity**
   You have the right to be treated with **respect, dignity, and courtesy**. You are entitled to receive care in an environment free from discrimination, harassment, and abuse.
6. **Right to Participate in Your Treatment Planning**
   You have the right to actively participate in decisions about your treatment plan, including discussing options, setting goals, and being involved in your care decisions.
7. **Right to Access to Records**
   You have the right to **access your medical records** upon request and in accordance with Nevada law. You may also request corrections to your health records if you believe they are inaccurate or incomplete.
8. **Right to File a Complaint**
   You have the right to file a **complaint** about the quality of care, services, or your experience at the clinic, without fear of retaliation. You may contact the **Nevada Department of Health and Human Services** for assistance with filing a complaint.
9. **Right to Informed Decisions Regarding Telehealth** (if applicable)
   If you are receiving telehealth services, you have the right to be fully informed about the **nature, benefits, and risks** of telehealth, as well as your rights in telehealth encounters. You may choose to participate in telehealth or opt for in-person services instead.

Patient Responsibilities

As a patient, it is important to take an active role in your health care. The following are your responsibilities:

1. **Provide Accurate Information**
   You are responsible for providing **accurate, complete, and up-to-date** information about your health history, current medications, and any other relevant health details that may affect your treatment.
2. **Follow the Treatment Plan**
   You are responsible for following the **treatment plan** outlined by your healthcare provider. If you are unable to follow the plan, you should discuss any concerns with your provider to explore alternatives.

3. **Respect the Rights of Others**
   You are responsible for treating **staff, providers, and other patients** with respect and courtesy. Harassment, discrimination, or disruptive behavior will not be tolerated.
4. **Maintain Appointments**
   You are responsible for keeping your **appointments** or notifying the clinic in advance if you need to cancel or reschedule. Failure to do so may result in missed appointments fees or delays in your care.
5. **Understand Financial Responsibilities**
   You are responsible for understanding the **cost of care**, including any co-pays, deductibles, or out-of-pocket expenses. You are also responsible for **paying your bills** in a timely manner and informing the provider about any financial concerns.
6. **Ask Questions and Seek Clarification**
   You are responsible for **asking questions** about your treatment, medications, and any aspect of your care that you do not understand. If at any time you are unsure about the information provided, you should seek clarification.
7. **Notify the Provider of Changes**
   You are responsible for informing your provider if you experience any **changes in your health condition**, including new symptoms, side effects from medications, or problems with treatment.
8. **Comply with Clinic Policies**
   You are responsible for adhering to the **policies** and procedures of the clinic or provider, including policies related to scheduling, cancellations, and behavior during appointments.
9. **Respect Confidentiality**
   You are responsible for respecting the **confidentiality** of other patients and providers within the clinic. Do not share confidential information about other patients or treatment plans.
10. **Emergency Care**
    If you are experiencing a medical emergency, you are responsible for seeking care **immediately** at the nearest **emergency department** or by calling **911**.

Patient Acknowledgment

By signing this form, I acknowledge that I have received, read, and understand the rights and responsibilities listed above. I understand that I have the right to ask questions about my care and that I am responsible for actively participating in my treatment and following the guidelines established by my provider. I also understand that failure to follow these responsibilities may affect the quality of care I receive.

Patient Name (Printed): _____ **Date of Birth: ___ / ___ / _____**

Patient Signature: _____ **Date: ___ / ___ / _____**

If the patient is a minor or unable to sign, the **legal guardian** or **representative** should sign:

Guardian/Representative Name (Printed): _____ **Relationship to Patient: _____**

Guardian/Representative Signature: _____ **Date: ___ / ___ / _____**